

Executive Summary of the NAEPP Expert Panel Report

Guidelines for the Diagnosis and Management of Asthma—Update on Selected Topics 2002

The National Asthma Education and Prevention Program (NAEPP) keeps clinical practice guidelines up to date by identifying selected topics on asthma that warrant intensive review based on the level of research activity reflected in the published literature or the level of concern in clinical practice. The NAEPP Expert Panel identified key questions about asthma management and used a systematic review of the evidence, conducted by the Agency for Healthcare Research and Quality Evidence Practice Center, to prepare answers and update recommendations for clinical practice.

The NAEPP Expert Panel Report: Update on Selected Topics 2002 presents up-to-date recommendations on:

Medications—long-term management of asthma in children with mild or moderate persistent asthma, combination therapy in moderate persistent asthma, and use of antibiotics to treat acute exacerbations of asthma

Monitoring—written action plans compared to medical management alone, and peak flow-based compared to symptom-based written action plans

Prevention—effects of early treatment on the progression of asthma

Medications

Long-Term Management of Asthma in Children

Question: Does chronic use of inhaled corticosteroids improve long-term outcomes for children with mild or moderate persistent asthma, compared to other asthma medications?

Answer: Strong evidence from clinical trials has established that inhaled corticosteroids improve control of asthma for children with mild or moderate persistent asthma compared to as-needed beta₂-agonists, as measured by prebronchodilator FEV₁, reduced airway hyperresponsiveness, improvements in symptom scores and symptom frequency, fewer courses of oral corticosteroids, and fewer urgent care visits or hospitalizations. Studies comparing inhaled corticosteroids to cromolyn, nedocromil, theophylline, or leukotriene receptor antagonists are limited, but available evidence shows that none of these long-term control medications appear to be as effective as inhaled corticosteroids in improving asthma outcomes. Studies comparing medications in children younger than 5 years of age are not available; recommendations are based on expert opinion and extrapolation from studies in older children. The NAEPP EPR-2 recommendations for treating children with mild or moderate persistent asthma have been revised. (See charts for Stepwise Approach for Managing Asthma.)



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For more information contact:
NHLBI Health Information Network
P.O. Box 30105
Bethesda, MD 20824-0105
phone: 301-592-8573; fax: 301-592-8563; TTY: 240-629-3255
Web: <http://www.nhlbi.nih.gov>

Asthma



Based on observational studies, it is the opinion of the Expert Panel that the initiation of long-term control therapy should be considered in infants and young children who have had more than three episodes of wheezing in the past year that lasted more than 1 day and affected sleep and who have risk factors for the development of asthma (parental history of asthma or physician-diagnosed atopic dermatitis or two of the following: physician-diagnosed allergic rhinitis, wheezing apart from colds, peripheral blood eosinophilia). This is in addition to previously recommended indications for starting long-term control therapy—i.e., in infants and young children requiring symptomatic treatment more than two times per week or experiencing severe exacerbations less than 6 weeks apart.

What are the long-term adverse effects of chronic inhaled corticosteroid use in children on the following outcomes: vertical growth, bone mineral density, ocular toxicity, and suppression of the hypothalamic-pituitary-adrenal (HPA) axis?

Strong evidence from clinical trials following children for up to 6 years shows that the use of inhaled corticosteroids at recommended doses does not have frequent, clinically significant, or irreversible effects on any of the outcomes reviewed. The NAEPP EPR-2 statements have been updated but not changed: Inhaled corticosteroids improve health outcomes for children with mild or moderate persistent asthma, and the potential but small risk of delayed growth is well balanced by their effectiveness.

Cumulative data in children suggest that low-to-medium doses of inhaled corticosteroids may have the potential of decreasing growth velocity (resulting in a small difference in height averaging 1 cm in the first year of treatment), but this effect on growth velocity is not sustained in subsequent years of treatment, is not progressive, and may be reversible. Cohort studies following children for more than 10 years suggest that final height is attained. Physicians should monitor the growth of children and adolescents taking corticosteroids by any route of administration and, if growth appears slowed, weigh the benefits of asthma control against the possibility of growth suppression or delay.

Studies including 6 years of observation indicate that low-to-medium doses of inhaled corticosteroids have no adverse effects on bone mineral density in children and no significant effects on the incidence of subcapsular cataracts or glaucoma. Studies show that, on average, persons may have only clinically insignificant effects, if any, of inhaled corticosteroids on HPA axis function, although there may be rare individuals who are more susceptible.

Combination Therapy

In patients with moderate persistent asthma who are receiving inhaled corticosteroids, does addition of another long-term control agent improve outcomes?

Strong evidence from clinical trials consistently indicates that use of long-acting inhaled beta₂-agonists added to low-to-medium doses of inhaled corticosteroids leads to improvements in lung function and symptoms and reduced supplemental beta₂-agonist use. Adding a leukotriene modifier or theophylline to inhaled corticosteroids or doubling the dose of inhaled corticosteroids also improves outcomes, but the evidence is not as substantial. The NAEPP EPR-2 recommendations for moderate persistent asthma have been revised: The preferred treatment for adults and children over 5 years of age is the addition of long-acting inhaled beta₂-agonists to low-to-medium doses of inhaled corticosteroids. Adjunctive therapy combinations have not been studied in children younger than 5 years of age. For this age group, it is the opinion of the Expert Panel that there are two preferred options for treating moderate asthma: either the addition of long-acting inhaled beta₂-agonists to a low dose of inhaled corticosteroids or medium-dose inhaled corticosteroids as monotherapy.

Use of Antibiotics To Treat Acute Asthma Exacerbation

Does adding antibiotics to standard care improve the outcomes of treatment for acute exacerbation of asthma?

Evidence from clinical trials suggests no benefit from antibiotic therapy for asthma exacerbations, whether administered routinely or when suspicion of bacterial infection is low. No studies have addressed the question of whether the addition of antibiotics to standard care improves the outcomes of treatment for asthma exacerbations when signs and symptoms suggest the possibility—but do not clearly indicate the presence—of bacterial infection. The NAEPP EPR-2 recommendation has not been changed: Antibiotics are not recommended for the treatment of acute asthma exacerbations except as needed for comorbid conditions—e.g., for those patients with fever and purulent sputum, evidence of pneumonia, or suspected bacterial sinusitis.

Monitoring

Written Action Plans Compared to Medical Management Alone

Compared to medical management alone, does the use of a written asthma action plan improve outcomes?

Data are insufficient to support or refute the benefits of using written asthma action plans compared to medical management alone. Seven studies compared medical management with written action plans to medical management without action plans. Beyond including instructions on the action plan to the intervention groups, four of these studies did not include asthma education for either the intervention or control groups; three of the studies included similar but limited asthma education for both intervention and control groups. Only one study included children. Significant limitations in study designs and methods in these studies preclude conclusions. For example, the studies showing no benefits of written action plans did not have sufficient power for comparisons between treatment and control groups, and the two studies reporting significant improvements with action plans had potential biases in patient selection, withdrawals, data collection, or analysis.

However, a Cochrane review of 25 studies comparing asthma self-management education interventions for adults to medical care without such education also contrasted those studies with self-management interventions that included written action plans to those that did not. The self-management interventions with written action plans had the greatest benefits, including reduced emergency department visits and hospitalizations and improved lung function.

The NAEP EPR-2 recommendations have not been changed: It is the opinion of the Expert Panel that use of written action plans as part of an overall effort to educate patients in self-management is recommended, especially for patients with moderate or severe persistent asthma and patients with a history of severe exacerbations.

Peak Flow-Based Compared to Symptom-Based Written Action Plans

Compared to a written action plan based on symptoms, does use of a written action plan based on peak flow monitoring improve outcomes?

Evidence neither supports nor refutes the benefits of written action plans based on peak flow monitoring compared to symptom-based plans in improving health care utilization, symptoms, or lung function. Just four studies, one including children, were available, and these studies had limitations (e.g., inadequate sample sizes and power to detect differences or potential bias in patient selection). The evidence does not clearly show that a peak flow-based action plan is better, but equivalent benefits have been demonstrated. Patient preferences and circumstances (e.g., inability to recognize or report signs and symptoms of worsening asthma) may warrant choosing peak flow monitoring. The NAEP EPR-2 recommendations have not been changed. It is the opinion of the Expert Panel that peak flow monitoring for patients with moderate or severe persistent asthma should be considered because it may enhance clinician-patient communication and may increase patient and caregiver awareness of the disease status and control.

Prevention

Effects of Early Treatment on Progression of Asthma



For patients with mild or moderate persistent asthma, does early intervention with long-term control therapy (i.e., inhaled corticosteroids) prevent progression of asthma as indicated by changes in lung function or severity of symptoms?

Evidence is insufficient to permit conclusions on the benefits of early treatment of asthma in preventing the progression of disease. The NAEP EPR-2 statements on disease progression have been revised. The assumption that children ages 5 to 12 with mild or moderate persistent asthma have a progressive decline in lung function has not been supported by a large, randomized, controlled clinical trial. The trial found that although inhaled corticosteroids provided superior asthma control during treatment, symptoms and airway hyperresponsiveness returned when treatment was discontinued. This suggests that, for this age group, treatment provides control but does not modify the underlying disease process. In contrast, prospective observational studies in other age groups suggest that a loss of lung function in children occurs in the first 3 to 5 years of life and can occur rapidly in adults with asthma. Adequate studies of whether treatment can prevent these declines in lung function have not yet been conducted.

Stepwise Approach for Managing Infants and Young Children (5 Years of Age and Younger) With Acute or Chronic Asthma

Classify Severity: Clinical Features Before Treatment or Adequate Control		Medications Required To Maintain Long-Term Control
	<u>Symptoms/Day</u> <u>Symptoms/Night</u>	Daily Medications
Step 4 Severe Persistent	Continual Frequent	<ul style="list-style-type: none"> ■ Preferred treatment: <ul style="list-style-type: none"> – High-dose inhaled corticosteroids AND – Long-acting inhaled beta₂-agonists AND, if needed, – Corticosteroid tablets or syrup long term (2 mg/kg/day, generally do not exceed 60 mg per day). (Make repeat attempts to reduce systemic corticosteroids and maintain control with high-dose inhaled corticosteroids.)
Step 3 Moderate Persistent	Daily > 1 night/week	<ul style="list-style-type: none"> ■ Preferred treatments: <ul style="list-style-type: none"> – Low-dose inhaled corticosteroids and long-acting inhaled beta₂-agonists OR – Medium-dose inhaled corticosteroids. ■ Alternative treatment: <ul style="list-style-type: none"> – Low-dose inhaled corticosteroids and either leukotriene receptor antagonist or theophylline. <p>.....</p> <p>If needed (particularly in patients with recurring severe exacerbations):</p> <ul style="list-style-type: none"> ■ Preferred treatment: <ul style="list-style-type: none"> – Medium-dose inhaled corticosteroids and long-acting beta₂-agonists. ■ Alternative treatment: <ul style="list-style-type: none"> – Medium-dose inhaled corticosteroids and either leukotriene receptor antagonist or theophylline.
Step 2 Mild Persistent	> 2/week but < 1x/day > 2 nights/month	<ul style="list-style-type: none"> ■ Preferred treatment: <ul style="list-style-type: none"> – Low-dose inhaled corticosteroid (with nebulizer or MDI with holding chamber with or without face mask or DPI). ■ Alternative treatment (listed alphabetically): <ul style="list-style-type: none"> – Cromolyn (nebulizer is preferred or MDI with holding chamber) OR leukotriene receptor antagonist.
Step 1 Mild Intermittent	≤ 2 days/week ≤ 2 nights/month	<ul style="list-style-type: none"> ■ No daily medication needed.

All Patients	<ul style="list-style-type: none"> ■ Bronchodilator as needed for symptoms ≤ 2 times a week. Intensity of treatment will depend upon severity of exacerbation. <ul style="list-style-type: none"> – Preferred treatment: Inhaled short-acting beta₂-agonist by nebulizer or face mask and space/holding chamber – Alternative treatment: Oral beta₂-agonist ■ With viral respiratory infection <ul style="list-style-type: none"> – Bronchodilator q 4–6 hours up to 24 hours (longer with physician consult); in general no more than once every 6 weeks – Consider systemic corticosteroid if exacerbation is severe or patient has history of previous severe exacerbations ■ Use of short-acting beta₂-agonist daily indicates the need to initiate or increase long-term control therapy
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 Step down Review treatment every 1 to 6 months; a gradual stepwise reduction in treatment may be possible.
 Step up If control is not maintained, consider step up. First, review patient medication technique, adherence, and environmental control.

<ul style="list-style-type: none"> ■ Minimal or no chronic symptoms day or night ■ Minimal or no exacerbations ■ No limitations on activities; no school/parent's work missed 	<ul style="list-style-type: none"> ■ Minimal use of inhaled short-acting beta₂-agonist (< 1x per day, < 1 canister/month) ■ Minimal or no adverse effects from medications
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- Note**
- The stepwise approach is intended to assist, not replace, the clinical decisionmaking required to meet individual patient needs.
 - Classify severity: assign patient to most severe step in which any feature occurs.
 - There are very few studies on asthma therapy for infants.
 - Gain control as quickly as possible (a course of short systemic corticosteroids may be required); then step down to the least medication necessary to maintain control.
 - Provide parent education on asthma management and controlling environmental factors that make asthma worse (e.g., allergies and irritants).
 - Consultation with an asthma specialist is recommended for patients with moderate or severe persistent asthma. Consider consultation for patients with mild persistent asthma.

